STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152524	A. BUILDING _____ B. WING _____	C 07/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DSI NORTHWEST INDIANAPOLIS RENAL CENTER	6488 CORPORATE WAY INDIANAPOLIS, IN 46278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 000	INITIAL COMMENTS This visit was a (CORE) ESRD federal complaint investigation survey. Complaint: #IN00129917 - Substantiated: No deficiencies related to the allegation are cited cited. Survey date: July 8, 9, and 10, 2013 Facility #: 006144 Medicaid Vendor: #201073800 Surveyor: Susan E. Sparks, RN, PH Nurse Surveyor Miriam Bennett, RN, PH Nurse Surveyor DSI Northwest Indianapolis Renal Center is in compliance with 42 CFR 494.70 Patient Rights, 494.80 Patient Assessment, and 494.14 Personnel Qualifications as related to this complaint. Quality Review: Joyce Elder, MSN, BSN, RN July 12, 2013	V 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE